		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045740

Facility Name: LaSalle HealthCare Center

Address: 1445 Chartres Street (Number) LaSalle (City) 61301 (Zip Code)

County: LaSalle

Telephone Number: (815) 223-4700 **Fax #** (815) 223-6630

IDPA ID Number: 36-2795206

Date of Initial License for Current Owners: 02/19/1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sherry L DeBons **Telephone Number:** (832) 467-6323

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Linda Holtzscheiter
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 1/1/2003 Ending: ########

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,222	2,231	4,940	16,393	8
9	SNF/PED					9
10	ICF	13,094	4,249	28	17,371	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,316	6,480	4,968	33,764	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.59%

D. How many bed-hold days during this year were paid by Public Aid?
18 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 01/01/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 01/01/1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 50 and days of care provided 4,940

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	148,252	8,275	6,720	163,247		163,247		163,247			1
2	Food Purchase		126,855		126,855	(223)	126,632		126,632			2
3	Housekeeping	76,573	9,638	1,950	88,161		88,161		88,161			3
4	Laundry	49,147	9,704		58,851		58,851		58,851			4
5	Heat and Other Utilities			82,285	82,285		82,285	34	82,319			5
6	Maintenance	34,335	19,617	9,714	63,666		63,666	211	63,877			6
7	Other (specify):* Waste/Garbage -See pg 3.1			14,531	14,531		14,531		14,531			7
8	**TOTAL General Services**	308,307	174,089	115,200	597,596	(223)	597,373	245	597,618			8
	B. Health Care and Programs											
9	Medical Director			10,211	10,211		10,211		10,211			9
10	Nursing and Medical Records	1,419,026	72,645	17,332	1,509,003		1,509,003	15,300	1,524,303			10
10a	Therapy	159,690	2,752	5,602	168,044		168,044		168,044			10a
11	Activities	61,491	5,070	2,877	69,438		69,438		69,438			11
12	Social Services	31,811	76	1,668	33,555		33,555		33,555			12
13	Nurse Aide Training											13
14	Program Transportation			270	270		270	(270)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,672,018	80,543	37,960	1,790,521		1,790,521	15,030	1,805,551			16
	C. General Administration											
17	Administrative	58,570			58,570		58,570		58,570			17
18	Directors Fees											18
19	Professional Services			310	310		310		310			19
20	Dues, Fees, Subscriptions & Promotions			18,995	18,995		18,995	(4,727)	14,268			20
21	Clerical & General Office Expenses	109,815	7,914	272,748	390,477		390,477	(59,527)	330,950			21
22	Employee Benefits & Payroll Taxes			448,382	448,382	223	448,605	(223)	448,382			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,975	7,975		7,975	12,785	20,760			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			94,650	94,650		94,650	(30,429)	64,221			26
27	Other (specify):*											27
28	**TOTAL General Administration**	168,385	7,914	843,060	1,019,359	223	1,019,582	(82,122)	937,460			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,148,710	262,546	996,220	3,407,476		3,407,476	(66,847)	3,340,629			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LaSalle HealthCare Center #0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,372	15,372		15,372	95,302	110,674			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(33)	(33)		(33)		(33)			32
33	Real Estate Taxes			27,494	27,494		27,494	(2,574)	24,920			33
34	Rent-Facility & Grounds			450,274	450,274		450,274	1,885	452,159			34
35	Rent-Equipment & Vehicles			5,925	5,925		5,925	1,302	7,227			35
36	Other (specify):* Home Office							11,427	11,427			36
37	TOTAL Ownership			499,032	499,032		499,032	107,342	606,374			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,424	65	93,489		93,489	14,667	108,156			39
40	Barber and Beauty Shops		1,252	9,967	11,219		11,219	(11,219)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):* X-Ray /Lab See Pg 4.1			5,760	5,760		5,760		5,760			43
44	TOTAL Special Cost Centers		94,676	71,089	165,765		165,765	3,448	169,213			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,148,710	357,222	1,566,341	4,072,273		4,072,273	43,944	4,116,217			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(223)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(270)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(335)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,835)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(167,920)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (179,583)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	223,527		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 223,527		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 43,944		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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LaSalle HealthCare Center

ID# **0045740**

Report Period Beginning: **01/01/2003**

Ending: **12/31/03**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (243)	21	1
2	Small Balance Adjustment	(1)	21	2
3	Memorium/ Benevolance	(1,063)	21	3
4	Depreciation Reconciliation	95,302	30	4
5	Activities Program Receipts	0	11	5
6				6
7	Professional liability Insurance	(30,911)	26	7
8	Barber & Beauty	(11,219)	40	8
9	Public Relations Expenses	0	20	9
10	Non Allowable Advertising	(4,639)	20	10
11	Entertaiment	(860)	24	11
12	Fresh Start	0	36	12
13	Civic Dues	(1,222)	20	13
14	Penalities	(5,980)	21	14
15	Vending reciepts	0	21	15
16	Misc Reciepts	(1,019)	21	16
17	Marketing Wages	0	21	17
18	Marketing Bonus	0	21	18
19	Marketing Holiday	0	21	19
20	Maketing Sick	0	21	20
21	Marketing Vacation	0	21	21
22	Marketing Overtime	0	21	22
23	Marketing Non Worked Wages	0	21	23
24	Adjust Property Taxes to actual	(2,817)	33	24
25	Legal Fees - Bankrupcty	0	21	25
26	Legal Structure Management Fees	(207,841)	21	26
27				27
28				28
29	*** This facility re-valued their assets in 1999.			29
30	We have reported the Historial Cost of the assets			30
31	consistent with the prior years, and have ensured			31
32	that depreciation expense is reported on straight			32
33	line. This adjustment is necessary to reverse the			33
34	re-valuation of Historial Cost. (per CR YR 2000)			34
35				35
36	Asset < $ 500 Asset # 5053	2301	21	36
37	Asset < $ 500 Asset # 5054	1486	21	37
38	Asset < $ 500 Asset # 5055	806	21	38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(167,920)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LaSalle HealthCare Center # 0045740 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	34	0	0	0	0	0	0	0	0	0	34	5
6	Maintenance	0	211	0	0	0	0	0	0	0	0	0	211	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	245	0	0	0	0	0	0	0	0	0	245	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	15,300	0	0	0	0	0	0	0	0	0	15,300	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(270)	0	0	0	0	0	0	0	0	0	0	(270)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(270)	15,300	0	0	0	0	0	0	0	0	0	15,030	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,861)	1,134	0	0	0	0	0	0	0	0	0	(4,727)	20
21	Clerical & General Office Expenses	(222,724)	163,197	0	0	0	0	0	0	0	0	0	(59,527)	21
22	Employee Benefits & Payroll Taxes	(223)	0	0	0	0	0	0	0	0	0	0	(223)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(860)	13,645	0	0	0	0	0	0	0	0	0	12,785	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(30,911)	482	0	0	0	0	0	0	0	0	0	(30,429)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(260,580)	178,458	0	0	0	0	0	0	0	0	0	(82,122)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(260,850)	194,003	0	0	0	0	0	0	0	0	0	(66,847)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LaSalle HealthCare Center # 0045740 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	95,302	0	0	0	0	0	0	0	0	0	0	95,302	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(2,817)	243	0	0	0	0	0	0	0	0	0	(2,574)	33
34	Rent-Facility & Grounds	0	1,885	0	0	0	0	0	0	0	0	0	1,885	34
35	Rent-Equipment & Vehicles	0	1,302	0	0	0	0	0	0	0	0	0	1,302	35
36	Other (specify):*	0	11,427	0	0	0	0	0	0	0	0	0	11,427	36
37	**TOTAL Ownership**	92,485	14,857	0	0	0	0	0	0	0	0	0	107,342	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	14,667	0	0	0	0	0	0	0	0	0	14,667	39
40	Barber and Beauty Shops	(11,219)	0	0	0	0	0	0	0	0	0	0	(11,219)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(11,219)	14,667	0	0	0	0	0	0	0	0	0	3,448	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(179,583)	223,527	0	0	0	0	0	0	0	0	0	43,944	45

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attachment page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 34	$ 34	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	211	211	2
3	V	39	Professional Services		Mariner Health Care	100.00%	14,667	14,667	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Health Care	100.00%	1,134	1,134	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	15,300	15,300	5
6	V	21	Clerical & General Office Exp		Mariner Health Care	100.00%	163,197	163,197	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	13,645	13,645	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%	353	353	8
9	V	36	Depreciation		Mariner Health Care	100.00%	11,427	11,427	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	243	243	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	1,302	1,302	11
12	V	34	Leasse Expense		Mariner Health Care	100.00%	1,885	1,885	12
13	V	26	Property Insurance		Mariner Health Care	100.00%	129	129	13
14	Total			$			$ 223,527	$ * 223,527	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$ 198	$		$ 34	1
2	6	Repair & Maintenance				1,236			211	2
3	39	Professional Services				85,755			14,667	3
4	20	Fees, Subscriptions, Promotions				6,630			1,134	4
5	10	Nursing & Medical Records				77,611			15,300	5
6	21	Clerical & General Office Exp				966,018			163,197	6
7	24	Travel & Seminar				79,781			13,645	7
8	26	Insurance Premium				2,063			353	8
9	36	Depreciation				66,810			11,427	9
10	33	Taxes - Property				1,419			243	10
11	35	Rental & Leasing				7,615			1,302	11
12	34	Leasse Expense				11,019			1,885	12
13	26	Property Insurance				753			129	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,306,908	$		$ 223,527	25

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 23,165	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 23,677	2
3. Under or (over) accrual (line 2 minus line 1).		$ 512	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 26,982	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 27,494	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	25,172	8
	1999	31,824	9
	2000	24,143	10
	2001	23,548	11
	2002	23,548	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LaSalle HealthCare Center COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0045740

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE (832) 467-6323 FAX #: (832) 467-6336

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200.

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-09-451-000	PT E 1/2 SE-BEG891.02 NE COR, S	$ 23,280.30	$ 22,280.30
2.	17-09-449-000	PT SE-4-9-33-1 BEG 1291.02' S NE	$ 1,202.54	$ 1,202.54
3.	17-09-450-000	IRREG .19ACS NE SE	$ 194.16	$ 194.16
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,677.00	$ 23,677.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,694 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [x] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	See Attached Schedules			1984	24,032	1,203	20	1,203		23,261	9
10	See Attached Schedules			1985	50,750	2,537	20	2,537		47,171	10
11	See Attached Schedules			1986	327	16	20	16		291	11
12	See Attached Schedules			1987	5,631	283	20	283		4,602	12
13	See Attached Schedules			1988	4,260	213	20	213		3,272	13
14	See Attached Schedules			1989	8,947	447	20	447		6,431	14
15	See Attached Schedules			1990	19,986	1,000	20	1,000		13,008	15
16	See Attached Schedules			1991	158,584	8,126	20	8,126		99,767	16
17	See Attached Schedules			1992	28,134	1,406	20	1,406		16,389	17
18	See Attached Schedules			1993	95,566	4,778	20	4,778		51,190	18
19	See Attached Schedules			1994	25,902	1,295	20	1,295		12,203	19
20	See Attached Schedules			1992	7,158	359	20	359		4,889	20
21	See Attached Schedules			1993	23,691	1,185	20	1,185		12,091	21
22	See Attached Schedules			1995	14,934	747	20	747		5,515	22
23	See Attached Schedules					8,901		8,901			23
24											24
25	Parking Lot Repairs			1996	2,400	120	20	120		888	25
26	Door & Frames			1996	1,679	84	20	84		626	26
27	Therapy Additions			1997	5,709	591	8.5	591		3,646	27
28	Therapy Room			1997	7,232	843	8.5	843		5,196	28
29	A/C repair			1996	1,120	56	20	56		436	29
30	Fire Alarm Systems			1996	14,927	746	20	746		5,523	30
31	Plumbing Repair			1996	772	39	20	39		279	31
32											32
33	Security System			1998	806	40	20	40		218	33
34	Exterior Sign/Flagpole			1998	3,221	268	20	268		1,409	34
35	Water Heater			1998	5,634	232	20	232		1,266	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Allocation -Mariner Post Acute		$	$ 38,347		$ 38,347	$	$ 153,388	37
38									38
39	1:90 Gal Water Heater	2000	4,700	470	10	470		2,193	39
40									40
41	7.5 Ton Carrier RoofTop Instl	2001	8,250	825	10	825		2,338	41
42	W/N/C RTU Condenser, Evapcoil	2001	4,842	323	15	323		861	42
43									43
44	Rlpc Commerical Water Heater	2002	6,401	640	10	640		1,271	44
45	6-Interior & 1-entrance Door	2002	15,415	771	20	771		1,028	45
46	Rprs Leak under Concrete Floor	2002	1,090	55	20	55		86	46
47	Repl Water Heater	2002	6,850	685	10	685		1,085	47
48									48
49									49
50	Rplc VCT Cove Base	2003	5,000	208	10	208		208	50
51	Rplc Trane Rooftop Unit	2003	4,595	421	10	421		421	51
52	Custom Made Book Cases/Serv Co	2003	6,523	254	15	254		254	52
53	Instl Charge- Nuse call System	2003	4,137	241	10	241		241	53
54	Nurse Call System Equipo	2003	4,607	307	10	307		307	54
55	Rplc VCT- Cove Base -Final Due	2003	5,412	225	10	225		225	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 589,224	$ 79,288		$ 79,288	$	$ 483,473	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 279,662	$ 27,268	$ 27,268	$	10	$ 225,907	71
72	Current Year Purchases	62,709	4,119	4,119		10	4,119	72
73	Fully Depreciated Assets	203,187					203,187	73
74								74
75	TOTALS	$ 545,558	$ 31,387	$ 31,387	$		$ 433,213	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,134,782	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 110,674	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 110,674	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 916,686	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 06/01/1996	$ 772	$ 39	$ 295	86
87	O/H Allocation 12/01/1996	1,531	77	545	87
88	O/H Allocation 08/01/1997	464	23	148	88
89	O/H Allocation 10/01/1997	215	11	69	89
90					90
91	TOTALS	$ 2,982	$ 150	$ 1,057	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nationalwide Health Properties

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1973	101	07/01/89	$ 450,274	10	40	3
4	Additions							4
5								5
6								6
7	TOTAL		101		$ 450,274 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/1989
Ending 06/01/2006

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a -03	2159	hrs	$ 41,500		$	$	2,159	$ 41,500	1
2	Licensed Speech and Language Development Therapist	10a -03	621	hrs	26,219				621	26,219	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a -03	3714	hrs	91,971				3,714	91,971	4
5	Physician Care	39 - 03		visits		1	65		1	65	5
6	Dental Care	39 - 03		visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39 - 03		# of prescrpts				93,424		93,424	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39 - 03		hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): HO Profess Svcs							14,667		14,667	13
14	TOTAL				$ 159,690	1	$ 65	$ 108,091	6,495	$ 267,846	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number LaSalle HealthCare Center # 0045740 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,150	$	1
2	Cash-Patient Deposits	32,717		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	483,183		3
4	Supply Inventory (priced at)	15,020		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attachment Schd 17.1			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 532,070	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	66,074		15
16	Equipment, at Historical Cost	130,059		16
17	Accumulated Depreciation (book methods)	(41,436)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attachment Schd 17.1			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 154,697	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 686,767	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 7,190	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(1,019)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,922		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,939		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,554		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attachment Schd 17.1	51,282		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 240,868	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attachment Schd 17.1	(552,290)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (552,290)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (311,422)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 998,188	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 686,766	$	48

***(See instructions.)**

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,132,856	1
2	Restatements (describe):		2
3	**Move CYRE to Retained Earning**	(2,259,000)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 873,856	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	124,328	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 124,328	17
	B. Transfers (Itemize):		
18	**Rounding**	4	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 4	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 998,188	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,940,736	1
2	Discounts and Allowances for all Levels	(2,536,317)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,404,419	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	502,667	6
7	Oxygen	50,349	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 553,016	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,260	13
14	Non-Patient Meals	183	14
15	Telephone, Television and Radio	7,579	15
16	Rental of Facility Space		16
17	Sale of Drugs	138,997	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,734	19
20	Radiology and X-Ray		20
21	Other Medical Services	42,397	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 238,150	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellanceous Receipts Admin	1,019	28
28a	Rounding	(3)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,016	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,196,601	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	597,596	31
32	Health Care	1,790,522	32
33	General Administration	1,019,359	33
	B. Capital Expense		
34	Ownership	499,032	34
	C. Ancillary Expense		
35	Special Cost Centers	110,468	35
36	Provider Participation Fee	55,297	36
	D. Other Expenses (specify):		
37			37
38	Rounding	(1)	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,072,273	40
41	**Income before Income Taxes (line 30 minus line 40)****	124,328	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 124,328	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,163	$ 58,714	$ 27.14	1
2	Assistant Director of Nursing	1,665	1,816	38,860	21.40	2
3	Registered Nurses	13,129	14,316	305,300	21.33	3
4	Licensed Practical Nurses	12,509	13,640	269,298	19.74	4
5	Nurse Aides & Orderlies	64,261	70,072	690,359	9.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,287	3,592	105,597	29.40	7
8	Rehab/Therapy Aides	2,655	2,901	54,093	18.65	8
9	Activity Director	1,946	2,082	22,971	11.03	9
10	Activity Assistants	5,120	5,477	38,520	7.03	10
11	Social Service Workers	3,257	3,572	31,811	8.91	11
12	Dietician					12
13	Food Service Supervisor	1,924	2,035	33,462	16.44	13
14	Head Cook	8,115	8,583	70,027	8.16	14
15	Cook Helpers/Assistants	6,174	6,530	44,763	6.85	15
16	Dishwashers					16
17	Maintenance Workers	3,158	3,398	34,335	10.10	17
18	Housekeepers	10,704	11,330	76,573	6.76	18
19	Laundry	6,180	6,666	49,147	7.37	19
20	Administrator	1,982	2,140	74,620	34.87	20
21	Assistant Administrator					21
22	Other Administrative	1,963	2,119	38,965	18.39	22
23	Office Manager					23
24	Clerical	3,775	4,075	54,800	13.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,793	2,001	17,601	8.80	31
32	Other Health Ca Care Coor & Case	1,987	1,987	38,895	19.57	32
33	Other(specify) Rounding			(1)		33
34	TOTAL (lines 1 - 33)	157,568	170,495	$ 2,148,710 *	$ 12.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	127	$ 5,073	1 - 3	35
36	Medical Director	64	10,100	9 - 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	336	15,300	10 -3	38
39	Pharmacist Consultant	143	6,161	10 -3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	34	1,883	11 - 3	44
45	Social Service Consultant	30	1,668	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	734	$ 40,185		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0	10 - 3	50
51	Licensed Practical Nurses	0	0	10 - 3	51
52	Nurse Aides	0	0	10 - 3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathleen Dilbeck	Adminstrator	100%	$ 58,570
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 58,570

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Legal fees	$ 310
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 310

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,701
Unemployment Compensation Insurance	46,122
FICA Taxes	153,500
Employee Health Insurance	162,255
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension / retirment	5,806
insurance Life	2,506
Other Benefits	6,492
Home Office Allocation	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 448,382

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,672
Health Care Worker Background Check	
(Indicate # of checks performed)	2,052
Other Licenses Fees	3,062
Dues	5,374
Home Office Allocation	1,134
Total Advertising	5,835
Less: Public Relations Expense	(1,222)
Non-allowable advertising	(4,639)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,268

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,960
In-State Travel	3,966
Home Office allocation	12,785
Seminar Expense	2,049
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,760

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LaSalle HealthCare Center # 0045740 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois HealthCare Association - $4,767**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,104** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,297**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **223** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **223**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/a** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	5,495
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	9,036
Garbage Service <> Default <> Physical Plant	0
	14,531

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Ending: 12/31/03

Meals - adjustment

33,764	Days (Total Patient days)
3	Mult (3 meals a day)
101292	Sub total
178	meals to employess (reported by facility)
101470	Add Sub
126855	Divide -Pg 3, line 2, column 2
1.25	Cost per day

1.25	Cost per day
178	mult - meal to employees
223	= adjust for pg 2, line 2, column2

Sales Tax - adjustment

126,855	Total Food Cost (page 3,Line 2, col 3)
0.01	Mult
1268.55	Sub total
19.19%	Mult (Pvt pay div by total census)
243	= adjust for nonallowable sale tax

for page 5A,

STATE OF ILLINOIS

Facility Name & ID Number LaSalle HealthCare Center # 0045740 Ending: 12/31/03

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	0
	-

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	5760
	5,760

Related Illinois Nursing Homes as of 12/31/2003

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HealthCare Center	0037689
	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Reconcile with schedule XV, line 9:	0
Difference	0

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	712
Misc Dedctns - Employee <> Union Dues <> Default	
Accruals - Insurance <> Accrue HMO Ins <> Default	
Accruals - Insurance <> Self Funded Ins Accr <> Default	47,680
Accruals - Insurance <> Basic Life <> Default	659
Accruals - Insurance <> Lt Dsblty <> Default	206
Accruals - Insurance <> Dental Ins <> Default	-
Accruals - Insurance <> Executive Supp Life <> Default	431
Accruals - Insurance <> Short Term Disability <> Default	612
Accruals - Insurance <> Dependent Life <> Default-Dept	84
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	45
Accruals - Insurance <> NES Insurance <> Default-Dept	853
L/T Debt - Current Portion <> Current Portion <> Default	
Total	51,282
Reconcile with schedule XV, line 36:	51,282
Difference	-

OTHER NON-CURRENT ASSETS:	
Excess Reorganized Value <>Excess Reorg Value <> Default	
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	
Total	-
Reconcile with schedule XV, line 23:	0
Difference	-

OTHER NON-CURRENT LIABILITIES::	
Intercompany - Revolver <> Default <> Default	(552,290)
N/P - Mortgage <> Mortgages <> Default	
Total	(552,290)
Reconcile with schedule XV, line 43:	(552,290)
Difference	0

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	0
Miscellaneous Receipts<>Default<>Prod<>Vending	
Miscellaneous Receipts<>Default<>Prod<>Administrative	1,019

	Total	1,019.00	Difference
Reconcile with schedule XVII, line 28:		1,019	0

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	-
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-
Miscellaneous Receipts<>Default<>Prod<>Activities	

	Total	-	Difference
Reconcile with schedule XVII, line 28a:		0	-